PCMA
PHARMACEUTICAL CARE
MANAGEMENT ASSOCIATION

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Before the

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY & COMMERCE
HEALTH SUBCOMMITTEE

Examining the Federal Government's Partnership with America's Pharmacists

May 23, 2006

Good Morning Chairman Deal, Ranking Member Brown and all the Members of the Health Subcommittee. I am Mark Merritt, President and CEO of the Pharmaceutical Care Management Association (PCMA). I'm pleased to be here today to discuss how pharmacy benefit management (PBMs) companies and Medicare Part D plan sponsors are working together with pharmacies across America to deliver safe and affordable drugs to patients.

PCMA is the national association representing America's PBMs and Medicare Prescription Drug Plans (PDPs.) PCMA represents both independent, stand-alone PBMs and health plans' subsidiaries. Together, PCMA member companies administer prescription drug plans that provide access to safe, effective, and affordable prescription drugs for more than 200 million Americans in private and public health care programs, including five of the ten national Medicare Part D PDPs.

MARKET CHANGE AND CONSUMER DEMAND

By way of background, I want to share with you some information about what plans and PBMs do, and why we exist in today's marketplace.

As Members of this committee know, the pharmaceutical marketplace has changed significantly in the last 20 years with an unprecedented number of new drugs coming to market, many with "blockbuster" sales potential. A significant growth in utilization of prescription drugs began in the mid-1980s as a result of the availability of new medicines. As more and more people demanded access to these medicines, employers and the government expanded insurance coverage to include prescription drugs. In 1990, 31 percent of payments for prescriptions came from third-party payers and Medicaid; by 1999, that figure grew to almost 70 percent.[1] Health care payers soon realized that prescription drug cost growth was outpacing other areas of health benefits and began looking for solutions. The PBM industry as we know it today was born out of this need.

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[1] U.S. Department of Health and Human Services, *Report to the President: Prescription Drug Coverage, Spending, and Prices* (Washington: DHHS, April 2000).

PBMs' track record for delivering quality prescription drug benefits with generous savings for consumers and employers is a good one and one in which we are proud. PBMs do this by using cost containment, clinical and utilization management tools designed to balance the payers' need for affordability with the beneficiary's need for choice and access. Such tools include:

- Pharmacy and therapeutic (P&T) committee formulary development and review;
- pharmacy network management;
- negotiation and administration of product discounts, including manufacturer rebates;
- mail-service pharmacy;
- drug utilization review (DUR);
- generic substitution;
- clinical prior authorization and step therapy;
- consumer and physician education;
- disease management; and
- consumer compliance programs.

The results cannot be denied. A recent study published in *Health Affairs* by CMS actuaries revealed that prescription drug spending in 2004 slowed to its lowest growth rate in the past 10 years, rising 8.2 percent. Overall, health spending grew in 2004 at a 7.9 percent clip, down from 8.2 percent in 2003.[2] The study's authors cited four key reasons for the slowdown in prescription drug spending:

- Rapid growth in the use of lower-price generic drugs;
- Increased use of over-the-counter medications;
- A shift toward greater mail-order dispensing; and
- Reduced consumption of certain drugs over safety concerns.

[2] Smith, Cowan, Heffler, et al, CMS National Health Accounts Team, National Health Spending in 2004: Recent Slow-Down Led By Prescription Drug Spending, *Health Affairs*, 25, no. 1 (2006: 186 – 196.

MEDICARE PART D: NEW CHALLENGES AND OPPORTUNITY

Now plans and PBMs are bringing to Medicare the knowledge and experience developed through managing drug benefits in the commercial marketplace. The new Part D benefit approved by Congress in the Medicare Modernization Act of 2003 presents new opportunities and unique challenges for our industry.

The opportunities lie in the ability to extend the cost-saving and clinical management tools used so successfully in private plans to millions of seniors and the disabled in Medicare. In this regard, I believe we have met and are exceeding expectations set by Congress and Medicare beneficiaries.

Cost Savings

In a recent analysis of prescription drug spending trends, CMS actuaries found that program-wide Medicare prescription drug plans (PDPs) are achieving deeper-than-expected discounts of 27 percent – up markedly from the 15 percent discount projection they made a year earlier. In turn, these discounts are driving overall estimates of prescription-drug trend lower. According to the report, total prescription drug expenditure growth for 2006 is revised downward from 8.1 percent to 7.7 percent to reflect actual Part D discounts available.[3]

PCMA conducted its own survey of five member plans discounts on the top 100 drugs used by seniors. Our own data shows that PCMA member PDPs are saving beneficiaries an average of 35 percent on medications purchased at retail pharmacies and 46 percent for drugs dispensed through mail-service pharmacies when compared to pharmacy usual and customary prices.[4]

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[3] Borger, Smith, Truffer, et al, CMS National Health Accounts Team, "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs*, 25, no. 2 (2006): w61-w73.

[4] See "PCMA Analysis Finds Medicare Prescription Drug Discounts 'Real & Holding Steady' in First 30 Days" at http://www.pcmanet.org/newsroom/2006/pr_1_06/pr_2_06/pr_20706.htm. NOTE: PCMA's study compared only PCMA Member plan PDPs prices for the top 100 drugs used by seniors to average retail usual and customary drug prices found on the New York Attorney General's prescription Drug website at: http://www.nyagrx.org/. This study is not meant to be a comprehensive actuarial analysis of Medicare savings but a snap shot of possible savings available to beneficiaries compared to cash-paying customers.

And seniors like the program. A recent *Washington Post/ABC News Poll* reported that 63 percent of seniors said they were saving money with the new program and 74 percent said they had an easy time enrolling in the program.[5] Another recent poll performed by AARP found that 78 percent of those enrolled in a Medicare drug plan are satisfied with their plan.[6]

As we are all well aware, these results have not come without some effort. Implementing a program of this scale is a massive undertaking. I give Dr. Mark McClellan, Leslie Norwalk and all those at CMS great credit for the hard work they've done. Even with all the hard work, however, it would be unrealistic not to expect some challenges in the beginning.

Challenges

We were faced with data problems from the onset of enrollment. Some Medicare beneficiaries, particularly the low-income and dual-eligibles, were inadvertently enrolled in two different plans at the same time; due to late enrollment or incomplete files, some seniors did not get their enrollment information on time for the January 1 start date. These issues alone, as pharmacists and Members of this Committee are aware, created a lot of problems when beneficiaries showed up at the pharmacy counter without their drug card or with the wrong drug card. This, in turn, created long waits on telephone lines to clear up eligibility issues and link the right benefit with the right person.

Most of these start up problems have been resolved and operations are moving much more efficiently now. Part D plans have had to maintain significant flexibility in partnering with the government to resolve these issues and adjust to changing rules. For example, plans were initially asked to provide 30-days of transitional medicines to new enrollees; we ultimately provided 90-days of transitional medications. Plans waived co-pays or automatically placed individuals in low-copay tiers when information on eligibility and formulary status was missing. PCMA member Part D plans hired hundreds of additional staff to answer pharmacist and

[5] "Most Seniors Enrolled Say Drug Benefit Saves Money," Jeffrey Birnbaum, Claudia Deene, The Washingoton Post, April 12, 2006 at http://www.washingtonpost.com/wp-dyn/content/article/2006/04/11/AR2006041101685.html

[6] "New Medicare Drug Benefit is Meeting or Exceeding Expectations," AARP News Release, April 12, 2006 at http://www.aarp.org/research/press-center/presscurrentnews/medicare_drug_benefit.html

customer call lines that were beyond the scope of our initial contract requirements. All these activities added un-reimbursed costs to our plans. Throughout it all, our industry has worked collaboratively with CMS and has adapted to this changing environment. As a result, we have seen significant improvement in data file accuracy and ease of enrollment.

Aside from the practical details of signing up beneficiaries and getting their prescriptions filled, Part D represents a significant departure for PBMs from normal business practices. In our commercial business, we typically contract directly with employers or health plans to provide services to their employees and members. In Part D, we are selling our services directly to the consumer. What's more, we are making all our drug prices and formulary information available to consumers to help them make informed choices. This is the first time this type of information has ever been available on such a massive scale and it speaks to our member company's commitment to engage the consumer directly and incentive to ensure people are happy with the coverage they choose.

PLANS AND PBMs WORKING WITH PHARMACY

The increase in third-party coverage of prescription drugs, including the new Medicare Part D benefit, coupled with increasing competition from large retail chain pharmacies and recent Congressional action to reduce Medicaid payments for prescription drugs has challenged many pharmacists. As such, it is not possible to tie the financial woes some pharmacists are experiencing to any one source. Nor is it accurate to assume that the more competitive reimbursement that has accompanied these marketplace changes and government actions has had a universally negative impact on pharmacists.

PBMs have great respect for America's pharmacists. In fact, collectively, PCMA member companies employ over 4,000 pharmacists nationwide. We need pharmacists to help reach the consumers we serve. We believe pharmacists benefit in return. For example, today plans and PBMs contract with about 95 percent of the 55,000 pharmacies nationwide, meaning that virtually all pharmacies are in plan and PBM networks. By increasing access to drug coverage, we have also increased volume of prescription sales in pharmacies. Our electronic claims

processing systems have ensured that claims can be paperless and receive fast and efficient adjudication. Finally, we provide vital information to pharmacies that they may not have about individual patients and the drugs they take, such as possible drug-to-drug interactions and drug recall notices.

It is important to note all the elements of payment to pharmacies for filling prescription orders. Pharmacists are reimbursed for the ingredient cost of the drug, a dispensing fee for filling the order, and the patient co-pay (this is retained by the pharmacy.) PBM and plan contracts with pharmacists include all these components which make up pharmacy reimbursement and therefore it is important to view compensation as a whole as opposed to its individual elements.

Working with pharmacists, we believe we have brought value to payers and consumers and improved the efficiency of pharmacy transactions. But pharmacy today is about more than individual prescription fills at the drug counter; it is about coordinated patient care management that provides:

- Integrated data systems that allow for an understanding of a patient's complete drug history;
- Flexibility to design and tailor different clinical services to specific disease states and patient needs; and
- Accountability for both the cost of care and quality of patient outcomes.

Prompt Pay

Much has already been said regarding prompt payment of Medicare Part D claims to pharmacists. In light of the expressed concerns that pharmacists were not being paid in a timely manner under Part D, PCMA member companies recently publicly pledged to pay pharmacies submitting clean electronic Part D claims within 30 days.[7]

[7] See "PCMA Member Companies Pledge to Pay Medicare Pharmacy Claims Within 30 Days," at http://www.pcmanet.org/newsroom/2006/Pr_5_06/pr_05_05.htm

For some perspective on the issue, it helps to understand what is considered standard payment cycles in other health and pharmacy benefit programs. The industry standard for payment of clean claims filed electronically for doctors, hospitals, and other providers in Medicare Parts A & B is 30 days. A 30-day timeframe is the pharmacy-claims standard in 43 states and is the standard applied to the Federal Employee Health Benefit Plan (FEHBP), Members of Congress' own health plan. The 30-day standard is applied to medical providers in the commercial marketplace and for business transactions and payments associated with credit cards and utilities. A 30-day standard helps improve quality, ensure accurate payments, and prevent fraud and abuse, which costs the health care system billions of dollars annually and increases costs for consumers and purchasers.

It also helps to understand how payment systems work. Because we are processing literally millions of claims per day for over 55,000 pharmacies, it is extremely inefficient to pay on a per-claim basis. Consistent with how other health providers are paid, Part D plans batch process claims in order to write one check per payment cycle to pharmacies. This is a system pharmacy is very familiar with as it is how payment works in the private sector today.

Finally, it helps to understand the activities plans and PBMs engage in to adjudicate claims. Claims adjudicating involves more than simple verification of plan eligibility and formulary status. Plans and PBMs review individual claims not only to ensure they are "clean" from an auditing standpoint, but also for clinical management purposes. This typically involves large system audits that match claims against certain criteria to identify outliers that may indicate possible fraud or other abuses. Audit criteria include claims that have a high cost, involve excessive quantities, and/or may have incorrect dosages or days of supply. Claims that raise red flags require an auditor to contact the pharmacy to resolve. If there are recurrent red flags in auditing for a particular pharmacy, further more intensive reviews are needed that may include involving the prescribing physician. Such programs are important tools to ensure plans and PBMs are accountable to health payers.

Medication Therapy Management and Quality Improvement

Part D plans and PBMs support the inclusion of Medication Therapy Management (MTM) programs in the Part D benefit. All PDPs included MTM programs in their bids that were approved by CMS. In fact, we believe that many of the services PBMs helped pioneer, such as drug utilization review, disease and therapeutic management and drug compliance programs, meet many of the goals of this program. However, we are concerned about efforts to establish rigid rules for MTM participation and services that would create a one-size-fits-all standard for this program.

MTM requires a coordinated effort between payer, providers and beneficiary to truly be of value. With the average senior taking five or more medications and visiting two or more different doctors and multiple pharmacies per year, a complete drug history is critical to an effective MTM program. Individual pharmacists often do not have this history, but the drug plan does and therefore can ensure patients are not taking drugs that conflict with one another or that may have deadly interactions.

MTM requires flexibility in design as no single model meets the needs of different patients and disease states. Models may include working directly with a retail pharmacist or utilizing the pharmacist or health care professionals in a plan or PBM. Many clinical programs offered by plans and PBMs today have produced impressive results because they are able to refine and improve programs with experience and innovate around services that work and rid the program of those that don't. CMS intentionally allowed for flexibility and discretion in MTM services in Part D for this reason.

FLEXIBITY REMAINS KEY TO THE SUCCESS OF PART D

As businesses that negotiate many contracts with employers and pharmacists, we believe matters of payment and design of clinical services should be left to contractual agreements between plans and pharmacies, not micromanaged by the government. Doing so will only add additional costs to the Medicare program, its beneficiaries and taxpayers.

PCMA commissioned a cost-estimate of S. 2563 a bill recently introduced by Senator Thad Cochran (R-MS). This legislation would establish a prompt payment rule for Part D that would require pharmacy payment within 14 days for clean claims filed electronically and 30 days for clean claims filed on paper. Penalties would be assessed for claims not paid in that time frame. In addition, this legislation would place new requirements on the Part D MTM program, such as: mandating (as opposed to allowing flexibility, as current law does) what services MTM programs must provide; mandating the setting these services must be provided in (i.e., "face-to-face"); adding new network adequacy standards on health plans to ensure community-based pharmacies provide MTM services; and adding new requirement regarding fees paid to pharmacists.

This legislation is estimated to cost a total of $9.4 billion over ten years. Of that amount, $7.7 billion would be new federal Medicare outlays while $1.7 billion would come from increased beneficiary premiums.

While the Cochran bill would add substantial costs to the Medicare program, PCMA requested an examination of this proposal because it appears to be less onerous than other, more expansive measures pending in Congress that would, among other things, mandate dispensing fees that must be paid to pharmacists. PCMA believes strongly that theses measures would increase costs even more than the Cochran bill and that $9 billion is the minimum price tag of the various pharmacy proposals.

We believe this is an unacceptable and unneeded new cost burden on both taxpayers and Medicare beneficiaries and would urge Members to carefully consider this as they evaluate legislative proposals before them.

CONCLUSION

PCMA and its member plans are proud of our achievements in the first five months of this historic new program. We've faced hurdles along the way, but have worked collaboratively with

consumers, pharmacists, doctors, CMS and others to address them and put many of them behind us. We believe the services we provide and the results we are seeing speak to the high standards we place on quality and affordability. In short, we believe we are doing the job Congress and America's seniors have asked us to do.

I appreciate the opportunity to testify and am happy to answer any questions Members may have.